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DISEASES OF THE THROAT

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Acute tonsillitis is one of the most common diseases. Certain individuals are subject to its discomforts one or more times each year. Besides the soreness and difficulty in swallowing, there is usually a high elevation of temperature and considerable toxaemia manifested by backache, etc. Tonsillitis, in itself, is not a dangerous illness. It is a self-limited disease like scarlet fever, pneumonia, and typhoid fever. That is to say, when once developed it cannot be aborted. Certain text books claim it can be aborted, but I have yet to see a remedy which will accomplish such a result. It occurs at all seasons of the year but is most common in the colder months. It usually follows exposure to cold or wet, but occasionally arises without apparent cause.

Tonsillitis is a disease of young adult life but is seen in young children and occasionally in adults of mature years.

Acute tonsillitis is usually diagnosed without difficulty and is treated in a variety of ways, any one of which is about as good as another. Peritonsillar abscess, on the other hand, is often not diagnosed properly and the unfortunate patient suffers needless torture.

Peritonsillar abscess is not a disease of the tonsil but of the tissues behind and above the tonsil. Infection and inflammation take place in the space surrounding the organ. When pus has formed, the tension and pressure cause great suffering. The symptoms of peritonsillar abscess are much the same as tonsillitis in the early stages. Soon, however, the soreness and pain become greater. After several days the patient is unable to open the mouth and the pain becomes of a character which is almost intolerable. Ear ache is a frequent source of discomfort at this time and it is not infrequently mistaken for mastoiditis. The condition exists as long as the pus is confined which may be several days or as long as two weeks. After a time, the abscess breaks and a large amount of pus suddenly escapes. The relief from pain is usually immediate.

Allowing a patient to suffer day after day from a peritonsillar abscess is a very cruel practice, for it is easily opened as soon as the pus is formed. It is often a rather ticklish performance to one unaccustomed to it however, for the reason that the patient usually cannot open the mouth wide enough to allow a good view of the swollen structures.

There is no excuse for the physician who allows his patient to have repeated attacks of either tonsillitis or peritonsillar abscess. The modern tonsil operation removes forever the cause of either disease. I have never known either to recur after the tonsil had been thoroughly removed. *If the attack does recur, the tonsil was not completely removed.*

What are the indications for removing the tonsils? In general, whenever the tonsils are chronically diseased. The age of the patient makes little difference. Repeated attacks of tonsillitis or peritonsillar abscess, enlarged glands in the neck, frequent sore throats, attacks of rheumatism or neuritis, the various heart lesions in childhood, chorea, indigestion, etc., are all frequent and excellent causes for removing the tonsils when the organs are diseased.

Is the tonsil operation a dangerous one? Most decidedly it is. What is the danger? Post-operative hemorrhage. The modern tonsil operation is a far more serious procedure than it is usually considered. If it can be avoided, it should never be performed in a private house. It is distinctly a hospital operation. No physician should attempt to perform this operation unless he is able to ligate a bleeding vessel in the tonsillar space or to suture the tonsillar pillars together in case of hemorrhage. I know many surgeons who will perform all manner of major operations upon other parts of the body who could not be hired to touch a tonsil operation. Yet many physicians with little or no surgical training feel competent to perform it practically alone in private houses. The modern tonsil operation consists of removing the entire tonsillar organ. Nothing short of this will suffice. There are dozens of methods for removing the tonsil, and all manner of instruments have been devised for the purpose. Any method which does it cleanly and without mutilating the tissues may be employed. The sharper the instruments used, the less soreness follows. Blunt dissection was formerly supposed to be attended with greater safety. Such a theory is no longer held to be true by advanced operators. There is one method of removing tonsils which I believe is to be utterly condemned from every standpoint. That is the method of tearing the organs out with the end of the finger. This method offers no degree of safety over others and the attending swelling and discomfort make it inexcusable, though I must admit it is practiced by several specialists of great reputation who claim great virtue for the operation. Why such eminent men cling to this barbarous operation is beyond my comprehension.

The nurse who suddenly has a tonsillar hemorrhage to care for is in a position of great responsibility. What shall she do? If the hemorrhage is slight, place an ice collar upon the neck, keep the patient quiet and notify the physician in charge. Don't take chances with tonsillar hemorrhage no matter how trivial you may consider it. The bleeding may be more than you realize and your patient may suddenly collapse. Patients often swallow much more blood than attendants realize. Suddenly vomiting occurs and the attendant is horrified to see the amount of fresh blood which comes from the stomach.

If blood suddenly and without warning begins to pour from the patient's mouth, prompt and efficient action is demanded upon the part of the nurse. In such an emergency the best thing to do, which I know of, is to wrap the index finger with a thin layer of gauze, insert the finger into the mouth and hold the hemorrhage by pressure upon the source of the bleeding. When the tonsil is removed there is a very sizable cavity left behind. The bleeding occurs from a vessel or more than one vessel situated within this hole. If the space formerly occupied by the tonsil can be located with the tip of the gauze-wrapped finger, the hemorrhage can be controlled indefinitely. Several weeks ago a highly efficient nurse held a tonsillar hemorrhage in one of my patients for forty minutes, when it ceased and did not recur. This hemorrhage took place in a child, eight years of age, six hours after the operation. No further bleeding occurred. This was the first hemorrhage to occur in my practice for nearly three years and came about from no apparent cause, yet the following week a child died in the Boston City Hospital from tonsillar hemorrhage in spite of all efforts of the specialists and general surgeons to prevent it. This is the only case, to my knowledge, which ever died in that institution from tonsillar hemorrhage though probably more than fifty thousand such operations have been performed there. In the above case of death mentioned from tonsillar hemorrhage, it is only fair to state that there were certain elements in the case which we do not fully understand. I am very sure that all specialists have some fear of tonsillar hemorrhage. The greatest ear, nose, and throat specialist I ever knew feared a tonsillar hemorrhage more than anything else in his professional work.

Often the only way to stop a violent tonsillar hemorrhage is either to suture the tonsillar pillars together or to locate the bleeding vessel and ligate it. The former is the easier method in the average case. Suturing the tonsillar pillars is not a difficult procedure to a trained operator but would be a tremendous task to one not familiar with the work. The patient must be etherized—otherwise it is almost impossible to accomplish the feat.

Adenoids are organs almost identical with tonsils in form and structure. They are situated at the junction of the nose and throat.

This is at the extreme upper part of the throat which lies behind the soft palate. Most people think adenoids are abnormal growths. This is not true. They are normal tissues, but they very frequently become so enlarged that they are a menace to health.

Enlarged adenoids occur mostly in children and young adults from one to twenty years of age. They are often seen in children but a few months old, and are also occasionally seen in adults, fifty or even sixty years of age. The consideration of adenoids is a very important subject inasmuch as they cause most of the disease occurring in the middle ear and mastoid in childhood. They are also responsible to a very large extent for weak, undeveloped children who suffer from lack of nasal breathing.

There is no age limit when adenoids are present or absent. Each individual case must be considered by itself. Many family physicians have stated that adenoids should not be removed before the fourth, sixth, or tenth year, depending upon the physician's individual idea of the matter. This is a common and serious mistake. I have seen many middle ear abscesses and cases of mastoiditis result from such advice. Twice within the year I have removed adenoids from three and four month old babies, each time with good results. Frequently children under two years of age require adenoid operations to prevent or overcome middle ear disease.

Ten years ago the Aural Department of the Boston City Hospital was overrun with children having chronic middle ear disease. Today, such cases are comparatively rare in our clinic. This is due to the large number of adenoid operations which are performed there. (More than three thousand adenoid operations were performed last year in the Boston City Hospital.)

Ear aches in childhood are almost entirely due to the presence of adenoids. The same may be said of mouth breathing.

Unlike tonsil operations, the removal of adenoids is practically devoid of danger. I have known of very few cases of post-operative hemorrhage following the removal of adenoids alone. On the other hand, the adenoid operation requires considerable skill to thoroughly remove all the adenoid tissue. No part of an adenoid operation can be seen. It must all be done by the sense of touch. Because of the profuse hemorrhage which occurs at the time of the operation, it must be done quickly. Many such operations woefully fail to remove the entire adenoid mass and the operation has been unjustly accused of failure because of the lack of skill or experience upon the part of the operator.